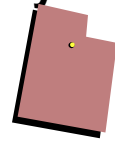




DEPARTMENT OF HUMAN SERVICES Health Insurance Portability and Accountability Act



February 2002

The purpose of this document is to assist DHS providers of health care services to understand and plan for the implementation of the HIPAA requirements. This guide should be used as a supplement to the HIPAA standards. Providers must familiarize themselves with the final HIPAA rules. If any of this information is later determined inaccurate, the Federal Register will govern.

WHAT IS HIPAA?

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law was to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs.



HIPAA is divided into five titles or sections. Each title addresses a unique aspect of health insurance reform. Title I is portability and it has been fully implemented. Portability allows individuals to carry their health insurance from one job to another so that they do not have a lapse in coverage. It also restricts health plans from requiring pre-existing conditions on individuals who switch from one health plan to another.

Title II is called Administrative Simplification and it will have the greatest impact on providers. It is designed to:

- + Combat health care fraud and abuse;

- + Guarantee security and privacy of health information;
- + Establish standards for health information and transactions; and
- + Reduce the cost of health care by standardizing the way the industry communicates information.

The remaining titles are:

- + Title III – Tax-Related Health Provisions
- + Title IV – Application and Enforcement of Group Health Plan Requirements
- + Title V – Revenue Offsets

WHAT IS ADMINISTRATIVE SIMPLIFICATION?

Administrative Simplification is the establishment of a set of standards for receiving, transmitting and maintaining healthcare information and ensuring the privacy and security of individual identifiable information. HIPAA establishes standards for electronic health care transactions, national code sets, and unique identifiers for providers, health plans, employers and individuals.



The HIPAA electronic data requirements are meant to encourage the healthcare industry to move the handling and transmission of patient information from manual to electronic systems in order to improve security, lower costs, and lower the error rate.

WHY STANDARDIZE ELECTRONIC TRANSACTIONS?

Standardization has been very effective in many industries. Anywhere in America you can plug in a US manufactured toaster and it will work because a standard voltage was



established for small appliances. However, if you take the toaster to Poland, it will only work if you use a special converter. If you go to Sudan you will have to

use still another converter. The electronic claims process in the United States is like the worldwide electric industry, no standardization. When administrative simplification has been implemented, providers will be able to submit an electronic claim in the same format to any healthcare plan.

WHAT ARE THE SPECIFIC PROVISIONS OF ADMINISTRATIVE SIMPLIFICATIONS?

+ **Transaction and Code Sets:** HIPAA mandates the development and use of standardized transactions for the electronic exchange of data. In addition, the use of standardized national codes sets to identify medical conditions, treatments, providers, individuals, and procedures are required. These regulations have been finalized and implementation is mandated for October 16, 2002, however approved extensions are available until October 16, 2003.

+ **Privacy:** Provides for the protection of individually identifiable health information that is transmitted or maintained in any form or medium.

These regulations have been finalized and implementation is mandated for April 14, 2003.

The privacy rule will affect the day-to-day business operations of all organizations that provide medical care and maintain personal health information.

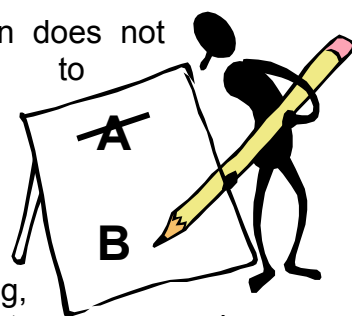
+ **Security Standards:**

Security Standards are designed to protect health care information as it is being stored and exchanged. It also includes provisions to verify the identity of those sending and receiving health care information electronically. The security rule has not been finalized, however, some of the security standards will be implemented as part of the privacy rule.



HOW DO THE HIPAA STANDARDS AFFECT PAPER TRANSACTIONS?

The HIPAA legislation does not require providers to discontinue submitting paper claims. However, HIPAA may require changes to several aspects of paper billing, such as changes to codes and required data elements.



WHO MUST COMPLY?

HIPAA requires the following entities to comply:

+ **Health Care Providers:** Any provider of medical or other health

services, who bills or is paid for healthcare in the normal course of business. Health care includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status of an individual.



- + **Health Care Clearinghouse:** Entities that process or facilitate the processing of health information received from other entities. It includes groups such as physician and hospital billing services.
- + **Health Plans:** Includes individual or group plans that provide or pay the cost of medical care and includes both the Medicare and Medicaid programs.

WHAT DOES THE PRIVACY RULE REQUIRE?

Providers will be required to:

- + **Guarantee patient privacy rights by:**
 - Giving patients clear, written explanations of how the provider may use and disclose their health information;
 - Ensuring patients can see and get copies of their records, and request amendments;
 - Making a history of non-routine disclosures accessible to patients;
 - Obtaining patient consent before sharing their information for

treatment, payment, and health care operations;

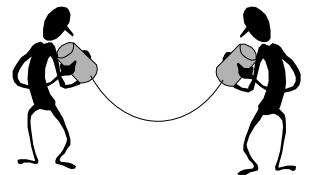
- Obtaining patient authorization for non-routine disclosures and most non-health care purposes; and,
 - Allowing patients to request restrictions on the uses and disclosures of their information.
- + **Adopt written privacy procedures, to include:**
 - Who has access to protected information,
 - How it will be used within the agency, and
 - When the information may be disclosed;
 - + **Ensure that business associates protect the privacy of health information;**
 - + **Train employees in the provider's privacy procedures; and,**
 - + **Designate a privacy officer who is responsible for ensuring the privacy procedures are followed.**

WHAT SHOULD PROVIDERS BE DOING?

Become informed:

Read and become familiar with the final HIPAA rules that can be found at:

<http://aspe.os.dhhs.gov/admsimp>



Other internet resources include:

- US Office of Civil Rights:
www.hhs.gov/ocr/hipaa
- HIPAA Implementation Guides:
www.wpc-edi.com
- HIPAA Primer:
www.hipaadvisory.com

+ **Assess impact of HIPAA:**

Evaluate current business processes to determine what needs to be done to ensure timely compliance. Specific attention should be addressed to:

- How claims are submitted
- How patient records are maintained, released and communicated
- How patient consent and authorization forms are maintained
- How referrals are given or received

+ **Contact outsourcing**

organizations: Contact any software vendors, billing services, or clearinghouses regarding potential upgrades to their products.

WHAT IS DHS DOING?

DHS has established two separate committees to ensure compliance with the Standard Transactions and Privacy Rules. These committees are currently working with federal and state representatives to determine how HIPAA applies to specific DHS programs, contracts, client privacy, and electronic processing.

WHO CAN PROVIDERS CONTACT?

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